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Surname	Date of birth
First Name	
Address	
Email address	
Telephone number	Mobile Number

I wish to have access to the following online services (please tick all that apply)

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Summary Care Record	
4. Accessing my medical record	

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice.	
2. I will be responsible for the security of the information that I see or download.	
3. If I choose to share my information with anyone else, this is at my own risk.	
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible.	
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	

Signature	Date

Patient DOB:		
Identity verified by (initials)	Date	Method
Authorised by		Date
Date account created		
Date password sent/given		
Photographic proof seen and verified		